JOHN V. EVANS
GOVERNOR

WAYNE L. SOWARD
DIRECTOR

STATE OF IDAHO
DEPARTMENT OF INSURANCE
700 W. STATE STREET
BOISE, IDAHO 83720
Phone: (208) 334-2250

B U L L E T I N NO. 85-2

TO: ALL INTERESTED PARTIES

FROM: WAYNE L. SOWARD, DIRECTOR
DEPARTMENT OF INSURANCE

SUBJECT: APPLICATION FOR REGISTRATION OF SELF-FUNDED EMPLOYEE HEALTH CARE PLAN

Title 41, Chapter 40, Idaho Code, supplemented by Department of Insurance Regulation No. 27 adopted August 7, 1974, provides for reasonable public supervision, by the Department of Insurance, State of Idaho, of "self-funded plans" as defined by Idaho Code §41-4002(6).

To facilitate this supervision, the above referenced Idaho Code and Regulation No. 27 mandate the registration of "self-funded plans" with the Department of Insurance, State of Idaho, in the manner prescribed by the Director of Insurance.

Effective immediately, formal applications to the Director of Insurance for the registration of "self-funded plans" must include the following:

Completed form SFP-1(3-85) (Exhibit A attached).

Submission of an advance non-refundable fee of $200.00 (required by Regulation No. 44, Section 3-A) payable to Department of Insurance, State of Idaho.

The completed application form SFP-1(3-85) shall be accompanied by:

A copy of the Trust Agreement under which the plan is to operate or is operating together with any amendments thereto.

A copy of the proposed written statement of benefits referred to in Idaho Code §41-4004(5).

(c) A current financial statement of the trust fund, if already in existence and operating. The statement shall be certified by an independent accountant.

(d) A written statement of projected income and disbursements of the trust fund for the twelve (12) month period commencing with the date of application and showing also the amount reserved as of the end of such period for claims incurred and not paid or incurred and not reported.

(e) A copy of any study made of the proposed "self-funded plan" by any consultant for the information or guidance of employer or employees.

(f) A copy of the Fidelity Bond issued by a surety authorized to do business in the State of Idaho covering individuals handling trust fund receipts and disbursements.

(g) A copy of the Administrative Agreement between the Trust and Administrator.

(h) A certification as to the actuarial soundness of the Plan by a qualified actuary. This certification must be by an actuary who is a member of the American Academy of Actuaries, and must include a detailed analysis of actuarial assumptions for projections of income and disbursements together with appropriate standards to be used for establishment of claim reserves.

(i) Such other relevant documentation and information as the Director may reasonably require or request.

DEPARTMENT OF INSURANCE
STATE OF IDAHO

Wayne L. Soward

WAYNE L. SOWARD
Director

March 27, 1985

STATE OF IDAHO
DEPARTMENT OF INSURANCE
700 W. STATE STREET
BOISE, IDAHO 83720

EXHIBIT A DATE: _____

APPLICATION FOR REGISTRATION OF SELF-FUNDED EMPLOYEE HEALTH CARE PLAN

_____
(Name of Trust Fund)

_____
(Address of Principal Office of Fund) (Phone No.)

Effective date of the Plan: _____

To the Director of Insurance of the State of Idaho:

STATE OF)
) ss
COUNTY OF)

_____, Employer(s) and

_____, Trustee, being duly sworn each for himself deposes and says that the information contained in this Application for Registration is true to the best of his knowledge and belief.

_____
Employer(s)

_____
Trustee

Subscribed and sworn to before me this
_____ day of _____, 19____

_____

My Commission Expires:

_____

Form SFP-1(3-85)

REGISTRATION

GENERAL INTERROGATORIES

1 Is this Plan maintained for the purpose of complying with any workers' compensation law or unemployment compensation disability insurance law?

_____

(If yes, describe)

2. Is this Plan administered by or for the Federal Government or agency thereof?

_____

(If yes, describe)

3. Is this Plan primarily for the purpose of providing first aid care and treatment, at a dispensary of the employer, for injury or sickness of employees while engaged in their employment?_____

If yes, describe)

4 Has this Plan been in existence and operation for a period of fifteen (15 years immediately prior to July 1, 1974?_____

If yes provide effective date of operation:_____

5 Is this a self-funded plan established for the sole purpose of funding the dollar amount of a deductible clause contained in the provisions of an insurance contract issued by an insurer duly authorized to transact disability insurance in this state? Please provide information as to the number of deductibles per family and deductible amount per person._____

_____

Please indicate number of beneficiaries insured and the total aggregate amount of all deductible obligations._____

_____

6. Give the names and addresses of the employer(s) for whose employee-beneficiaries the trust fund is operated.

_____

_____

_____

_____

7. Give the name and address of the administrator of the Plan.

_____

_____

_____

8. Give the names and addresses of the trustees of the Plan.

_____

_____

_____

9. Give the names and addresses of Plan consultants, if any.

_____

_____

_____

10. Give the names and addresses of insurance agents or brokers transacting business with the Plan, if any.

_____

_____

_____

_____

11. Give the names and addresses of associated or affiliated trust funds and/or Plans under control of management of the administrator or trustees named herein.

_____

_____

_____

_____

12. If benefits are provided by any means other than direct payments of a trust fund, please complete the following schedule and attach a copy of the group policy and/or other contract covering these benefits:

GENERAL DESCRIPTION OF BENEFIT	NAME & ADDRESS OF PERSON PROVIDING BENEFITS

13. Are all contributions to the Fund payable in advance?

_____

14. Does the Plan operate under the provisions of a Trust Agreement between the employer(s) and the trustee?_____

15. Have guidelines been established for trustees and administrators of the Plan?

_____

16. (a) If the Plan is already in operation, has each employee-beneficiary received, and will each future employee-beneficiary receive, a written statement or schedule adequately and clearly stating all benefits allowable under the Plan, together with all applicable restrictions, limitations and exclusions, and the procedure for filing a claim for benefits?

_____

(b) If the Plan is not yet in operation, will each beneficiary receive a written statement or schedule as described in (a) above?

_____

17. How often are the trust funds audited by an independent accountant?

_____

Name and address of auditing firm:_____

_____

18. (a) Have all individuals that will handle receipts and disbursements for the Trust Fund been bonded under a fidelity bond issued by a surety authorized to transact such surety business in the State of Idaho?

_____

If so, give name and address of surety_____

_____

and amount of fidelity coverage:_____

(b) Are individuals handling receipts and disbursement for the Trust Fund licensed as per Idaho Code Chapter 9, Title 41?_____

_____

19. Do you assert that this plan's program of coverage is qualified under the Employee Retirement Income Security Act (ERISA)?_____

If so, attach a copy of notice of this qualification from the United States Department of Labor.

20. Please complete the attached chart on page 6.

Benefit	BENEFITS CHECKED ARE PROVIDED				CONTRIBUTIONS ARE MADE BY		APPROX. NUMBER BENEFICIARIES COVERED	
	Directly Out of Trust Fund	By Insurance Carrier(s)	By Hospital and Medical Serv. Plans	Other (Specify)	Employer	Employee Payroll Deduction	Employees	Covered Deps.
Disability Income								
Hospital								
Medical								
Surgical								
Dental								
Vision Services								
Other (Specify)								